HARRIS COUNTY HCSO SHERIFF'S OFFICE
SHERIFF ED GONZALEZ
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HIPAA AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION & SUBSTANCE USE DISORDER CONSENT [42 CFR Part 2]

This form has been approved by the Office of Vince Ryan, Harris County Attorney's Office. Effective May 1, 2018.

Individual/Patient (Print)	**Date of Birth**	**SS# or Case #**	**Medicaid #**	**SPN**

I hereby authorize: ☐ **To disclose to:** ☐ **To Receive** **From:** _____ **Mail** _____

Name (Print):	Name (Print):
Street Address	Address:
City, State, Zip	City/State/Zip:
Phone and/or Fax:	Phone/Fax/Email:

my health information as listed below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive this information is not a covered entity as defined under federal privacy regulations, the disclosed information, except substance use disorder information, may no longer be protected by federal privacy regulations.

Date (s) of Service (if known): _____

Description of information to be disclosed: (check minimum necessary for purpose)

☐ Assessments	☐ Medical History	☐ Discharge Summary	☐ Educational
☐ Psychological Evaluation	☐ Service/Treatment Plans	☐ Physicians Orders	☐ Counseling
☐ Psychiatric Evaluation	☐ Medications Prescribed	☐ Laboratory Reports	☐ Alcohol/Substance Abuse
☐ HIV Information	☐ Diagnosis	☐ Progress Notes	☐ Vocational

☐ Other–specify: _____

_____

Description of the purpose of the use and/or disclosure: (check only what is applicable)

☐ Follow-up/Follow-along	☐ To aid in treatment planning	☐ Continuity of care
☐ Verification of maintaining appointments	☐ Financial/Insurance verification	☐ Monitor medical status
☐ Determine eligibility-Social Security Disability, etc.	☐ Medication Verification	☐ Legal proceedings/Court Updates
☐ Residential placement	☐ Assess/monitor treatment needs	☐ At individual/patient request

☐ Other – specify: _____

_____

Type of disclosure: ☐ Paper copy ☐ Inspect/review ☐ Verbal ☐ Electronic

Signature Page to Follow

SIGNATURE PAGE TO AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION & SUBSTANCE USE DISORDER CONSENT

Signature Authorization:
I have read this Authorization and agree to the uses and disclosures of the information as described. I understand that I do not have to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits will not be denied if I refuse to sign this Authorization. I also understand that refusing to sign this Authorization will not stop a disclosure of health information that has already occurred prior to a different authorization that I signed previously and that is still in effect, or a disclosure that is otherwise permitted by state or federal law without my specific consent, authorization or permission, including disclosures to Covered Entities or disclosures required by court order. **Finally, I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws**.

Effective Time Period:
I understand that this authorization **will expire within one year from the date of this Authorization** unless I otherwise specify.
This Authorization is effective until _____

Right to Revoke:
I understand that I may revoke this Authorization at any time by notifying - HCSO Medical Records Dept. at the above address in writing. I also understand that the written revocation must be signed and dated later than the date on this Authorization. The revocation will not affect any prior actions taken in reliance by entities that had permission to access my health information before the receipt of the written revocation.

_____ _____
Signature of Individual/Patient or Legally Authorized Representative Date Signed

_____
Print Name of Individual/Patient or Legally Authorized Representative

_____
If not signed by Individual/Patient, specify reason(s) for signing and relationship

A PHOTOCOPY OR FACSIMILE TRANSMISSION IS AS VALID AS THE ORIGINAL FOR TREATMENT, PAYMENT, EDUCATIONAL AND/OR BENEFIT DETERMINATION PURPOSES.

_____ Identity of requestor verified: Paper disclosure processed by: _____
Signature/Date Staff Printed Name/Initial/Date

☐ Picture ID ☐ Signature ☐ Known to me

Authorization revoked on: _____ And noted by _____ See signed revocation below or attached.
MM/DD/YYYY Staff printed name and initials

REVOCATION OF AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Individual/Patient Name: _____ SPN: _____

Date of Birth: _____ Social Security #: _____

As of this day, _____ , I take back my written permission that I previously gave to:
MM/DD/YYYY

_____ on _____
Date of authorization to be revoked

to disclose to/receive from: _____
Person/organization named on authorization to be revoked

health information about me. I understand that from today forward my health information will no longer be disclosed to the above noted person/organization unless I give my written permission.

_____ _____
Signature of Individual/Patient or Legally Authorized Representative Date Signed

_____
Print Name of Individual/Patient or Legally Authorized Representative

_____
If not signed by Individual/Patient, specify reason(s) for signing and relationship